	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	Carrier Claim Record - Encrypted Standard View	REC	VAR			Carrier claim record (other than DMERC) for version I of the NCH. The Encrypted Standard View supports the users of CMS data and provides the data in "text" ready format for easy conversion to ASCII text files. This file is also specifically processed to perform CMS standard encryption processes to perform CMS standard encryption processes for identifiable and personal health information data fields.
****	Carrier Claim Fixed Group - Encrypted Standard View	GROUP	215	1	215	Fixed portion of the Encrypted Standard View of the Carrier claim record for version I of the NCH Nearline File.
	1. Record Length Count	NUM	5	1	5	Effective with Version H, the count (in bytes) of the length of the claim record. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 5 DIGITS SIGNED SOURCE: NCH
	2. Record Number	NUM	9	6	14	An automatically assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.
	3. Record Type	NUM	2	15	16	Type of record CODES: 00 = Fixed Part of the Record

01 = Carrier Line Group
02 = Claim Demonstration ID Group
03 = Claim Diagnosis Group
04 = Claim Health PlanID Group
05 = Claim Occurrence Span Group
06 = Claim Procedure Group
07 = Claim Related Condition Group
08 = Claim Related Occurrence Group
09 = Claim Value Group
10 = MCO Period Gorup
11 = NCH Edit Group
12 = NCH Patch Group
13 = DMERC Line Group
14 = Revenue Center Group

4. Claim Sequence Number NUM 3 17 19 A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.

5. NCH Claim Type Code CHAR 2 20 21 The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPE
TITLE ALIAS: CLAIM_TYPE

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
  NCH CLM_NEAR_LINE_RIC_CD
  NCH PMT_EDIT_RIC_CD
  NCH CLM_TRANS_CD

```
  NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (Pre-HDC processing -- AVAILABLE IN NCH)
  CLM_MCO_PD_SW
  CLM_RLT_COND_CD
  MCO_CNTRCT_NUM
  MCO_OPTN_CD
  MCO_PRD_EFCTV_DT
  MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
FROM: (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD
NOTE:  From 7/1/97 to the start of HDC processing(?),
abbreviated inpatient encounter claims are not
available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  CARR_NUM
  CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM:  (AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

DERIVATION RULES:

  SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
  FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
```

```
2.   PMT_EDIT_RIC_CD EQUAL 'F'
3.   CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '0' OR '4'
4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
     OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '0' OR '4'
4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
     OR 'Z'
```

```
SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
3.   CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
3.   CLM_TRANS_CD EQUAL '6'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1.   FI_NUM = 80881
2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
     CLSFCTN_TYPE_CD = '2', '3' OR '4' &
     CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'I'
3.   CLM_TRANS_CD EQUAL 'H'
```

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
   MCO_OPTN_CD = 'C'
   CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
   MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
   ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
   TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or
   more line item(s) match the HCPCS on the
   DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING

CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

6. Beneficiary Birth Date	NUM	8	22	29	The beneficiary's date of birth. For the ENCRYPTED Standard View of the Carrier files, the beneficiary's date of birth (age) is coded as a range. 8 DIGITS UNSIGNED DB2 ALIAS: BENE_BIRTH_DT SAS ALIAS: BENE_DOB STANDARD ALIAS: BENE_BIRTH_DT TITLE ALIAS: BENE_BIRTH_DATE EDIT-RULES FOR ENCRYPTED DATA: 0000000R WHERE R HAS ONE OF THE FOLLOWING VALUES. 0 = Unknown 1 = <65 2 = 65 thru 69 3 = 70 thru 74 4 = 75 thru 79

					5 = 80 thru 84 6 = >84 SOURCE: CWF
7. Beneficiary Identification Code	CHAR	2	30	31	The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary. COMMON ALIAS: BIC DA3 ALIAS: BENE_IDENT_CODE DB2 ALIAS: BENE_IDENT_CD SAS ALIAS: BIC STANDARD ALIAS: BENE_IDENT_CD TITLE ALIAS: BIC EDIT-RULES: EDB REQUIRED FIELD CODES: REFER TO: BENE_IDENT_TB IN THE CODES APPENDIX SOURCE: SSA/RRB
8. Beneficiary Race Code	CHAR	1	32	32	The race of a beneficiary. DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD SAS ALIAS: RACE STANDARD ALIAS: BENE_RACE_CD SYSTEM ALIAS: LTRACE TITLE ALIAS: RACE_CD CODES: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic

6 = North American Native

SOURCE:
SSA

9. Beneficiary Residence SSA Standard County Code | CHAR | 3 | 33 | 35 | The SSA standard county code of a beneficiary's residence.

DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

10. Beneficiary Residence SSA Standard State Code | CHAR | 2 | 36 | 37 | The SSA standard state code of a beneficiary's residence.

DA3 ALIAS: SSA_STANDARD_STATE_CODE
DB2 ALIAS: BENE_SSA_STATE_CD
SAS ALIAS: STATE_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

CODES:
  REFER TO: GEO_SSA_STATE_TB
            IN THE CODES APPENDIX

COMMENT:
1. Used in conjunction with a county code, as
   selection criteria for the determination of
   payment rates for HMO reimbursement.
2. Concerning individuals directly billable for
   Part B and/or Part A premiums, this element
   is used to determine if the beneficiary
   will receive a bill in English or Spanish.
3. Also used for special studies.

						SOURCE: SSA/EDB
11.	Beneficiary Sex Identification Code	CHAR	1	38	38	The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD SAS ALIAS: SEX STANDARD ALIAS: BENE_SEX_IDENT_CD SYSTEM ALIAS: LTSEX TITLE ALIAS: SEX_CD EDIT-RULES: REQUIRED FIELD CODES: 1 = Male 2 = Female 0 = Unknown SOURCE: SSA,RRB,EDB
12.	Care Plan Oversight (CPO) Provider Number	CHAR	6	39	44	Effective with NCH weekly process date 3/7/97, the Medicare provider number of the HHA or Hospice rendering Medicare covered services during period the physician is providing care plan oversight. The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or Hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim. NOTE: On the Version G format, this field is stored as a redefinition of the NEAR_LINE_ORGNL_BENE_CAN_NUM (the first 3 positions contain 'CPO', followed by the 6-position provider number). During the Version H conversion the data was moved to this dedicated field. DB2 ALIAS: CPO_PRVDR_NUM SAS ALIAS: CPO_PROV

					STANDARD ALIAS: CPO_PRVDR_NUM TITLE ALIAS: CPO_PRVDR SOURCE: CWF
13. Carrier Claim Beneficiary Paid Amount	CHAR	13	45	57	Effective with Version H, the amount paid by the beneficiary for the non-institutional Part B services. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: CARR_BENE_PD_AMT SAS ALIAS: BENEPAID STANDARD ALIAS: CARR_CLM_BENE_PD_AMT TITLE ALIAS: BENE_PD_AMT EDIT-RULES: +9(9).99 SOURCE: CWF
14. Carrier Claim Cash Deductible Applied Amount	CHAR	13	58	70	Effective with Version H, the amount of the cash deductible as submitted on the claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: CASH_DDCTBL_AMT SAS ALIAS: DEDAPPLY STANDARD ALIAS: CARR_CLM_CASH_DDCTBL_APPLY_AMT TITLE ALIAS: CASH_DDCTBL EDIT-RULES: +9(9).99

						SOURCE: CWF
15.	Carrier Claim Diagnosis Code Count	NUM	1	71	71	The count of the number of diagnosis codes (both principal and other) reported on an carrier claim. The purpose of this count is to indicate how many claim diagnosis trailers are present. 1 DIGIT UNSIGNED DB2 ALIAS: CARR_DGNS_CD_CNT SAS ALIAS: CDGNCNT STANDARD ALIAS: CARR_CLM_DGNS_CD_CNT EDIT-RULES: RANGE: 0 TO 4 COMMENT: Prior to Version H this field was named: CLM_DGNS_CD_CNT. SOURCE: NCH
16.	Carrier Claim Line Count	NUM	2	72	73	The count of the number of line items reported on the carrier claim. The purpose of this count is to indicate how many line item trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: CARR_CLM_LINE_CNT SAS ALIAS: CLINECNT STANDARD ALIAS: CARR_CLM_LINE_CNT EDIT-RULES: RANGE: 1 TO 13 COMMENT: Prior to Version H this field was named: CWFB_CLM_NUM_LINE_ITM_CNT. SOURCE: CWFB CLAIMS
17.	Carrier Claim Payment	CHAR	1	74	74	The code on a noninstitutional claim indicating to

	Denial Code					whom payment was made or if the claim was denied. DB2 ALIAS: CARR_PMT_DNL_CD SAS ALIAS: PMTDNLCD STANDARD ALIAS: CARR_CLM_PMT_DNL_CD TITLE ALIAS: PMT_DENIAL_CD CODES: REFER TO: CARR_CLM_PMT_DNL_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_CLM_PMT_DNL_CD. SOURCE: CWF
18.	Carrier Claim Primary Payer Paid Amount	CHAR	13	75	87	Effective with Version H, the amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim. NOTE: During the Version H conversion, this field was populated with data throughout history (back to service year 1991) by summing up the line item primary payer amounts. 9.2 DIGITS SIGNED DB2 ALIAS: CARR_PRMRY_PYR_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: CARR_CLM_PRMRY_PYR_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT EDIT-RULES: +9(9).99 SOURCE: CWF
19.	Carrier Claim Provider Assignment Indicator Switch	CHAR	1	88	88	A switch indicating whether or not the provider accepts assignment for the noninstitutional claim. DB2 ALIAS: PRVDR_ASGNMT_SW

						SAS ALIAS: ASGMNTCD STANDARD ALIAS: CARR_CLM_PRVDR_ASGNMT_IND_SW TITLE ALIAS: ASSIGNMENT_SW CODES: A = Assigned claim N = Non-assigned claim COMMENT: Prior to Version H this field was named: CWFB_CLM_PRVDR_ASGNMT_IND_SW. SOURCE: CWF
20.	Carrier Claim Referring PIN Number	CHAR	14	89	102	Carrier-assigned identification (profiling) number of the physician who referred the beneficiary to the physician that performed the Part B services. This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier File. COMMON ALIAS: REFERRING_PHYSICIAN_PIN DB2 ALIAS: CARR_RFRG_PIN_NUM SAS ALIAS: RFR_PRFL STANDARD ALIAS: CARR_CLM_RFRG_PIN_NUM TITLE ALIAS: RFRG_PIN COMMENT: Prior to Version H this field was named: CWFB_CLM_RFRG_PHYSN_PRFLG_NUM. SOURCE: CWF
21.	Carrier Claim Referring UPIN Number	CHAR	6	103	108	The unique physician identification number (UPIN) of the physician who referred the beneficiary to the physician who performed the Part B services. This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier file. COMMON ALIAS: REFERRING_PHYSICIAN_UPIN DB2 ALIAS: CARR_RFRG_UPIN_NUM

					SAS ALIAS: RFR_UPIN STANDARD ALIAS: CARR_CLM_RFRG_UPIN_NUM TITLE ALIAS: REFERRING_PHYSICIAN_UPIN COMMENT: Prior to Version H this field was named: CWFB_CLM_RFRG_UPIN_NUM. SOURCE: CWF
22. Carrier Number	CHAR	5	109	113	The identification number assigned by HCFA to a carrier authorized to process claims from a physician or supplier. DB2 ALIAS: CARR_NUM SAS ALIAS: CARR_NUM STANDARD ALIAS: CARR_NUM SYSTEM ALIAS: LTCARR TITLE ALIAS: CARRIER CODES: REFER TO: CARR_NUM_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: FICARR_IDENT_NUM. SOURCE: CWF
23. Claim Blood Deductible Pints Quantity	CHAR	2	114	117	The quantity of blood pints applied (blood deductible) as reported on the carrier claim (non-DMERC). 3 DIGITS SIGNED DB2 ALIAS: BLOOD_DDCTBL_PT SAS ALIAS: BLD_DED STANDARD ALIAS: CLM_BLOOD_DDCTBL_PT_QTY TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE EDIT-RULES: NUMERIC

					COMMENT: Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer. SOURCE: CWF
24. Claim Blood Pints Furnished Quantity	CHAR	2	118	121	Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC). 3 DIGITS SIGNED DB2 ALIAS: BLOOD_PT_FRNSH_QTY SAS ALIAS: BLDFRNSH STANDARD ALIAS: CLM_BLOOD_PT_FRNSH_QTY TITLE ALIAS: BLOOD_PINTS_FURNISHED EDIT-RULES: NUMERIC COMMENT: Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer. SOURCE: CWF
25. Claim Excepted/Nonexcepted Medical Treatment Code	CHAR	1	122	122	Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted. DB2 ALIAS: EXCPTD_NEXCPTD_CD SAS ALIAS: TRTMT_CD STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD TITLE ALIAS: EXCPTD_NEXCPTD_CD

						CODES: 0 = No Entry 1 = Excepted 2 = Nonexcepted SOURCE: CWF
****	Claim Locator Number Group	GROUP	11	123	133	This number uniquely identifies the beneficiary in the NCH Nearline. STANDARD ALIAS: CLM_LCTR_NUM_GRP
26.	Beneficiary Claim Account Number	CHAR	9	123	131	The first nine characters identify the primary beneficiary under the SSA or RRB programs submitted. This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier file. STANDARD ALIAS: BENE_CLM_ACNT_NUM LIMITATIONS: RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.
27.	NCH Category Equatable Beneficiary Identification Code	CHAR	2	132	133	The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner. The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.) For the ENCRYPTED Standard View, this field contains the Beneficiary Identification Code. (See Field #7 of the FI Hospice Claim Fixed Group - Encrypted Standard View.)

CODES:
REFER TO: CTGRY_EQTBL_BENE_IDENT_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CTGRY_EQTBL_BENE_IDENT_CD.

SOURCE:
BIC EQUATE MODULE

28. Claim Payment Amount	CHAR	13	134	146	Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some pre-situations, a negative claim payment amount may be sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.) Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier total approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), pass PPS capital (since 10/1/91). It does NOT include the

medical

or

the

the

the rate

code =

then

center

amount.

APC

The

index

coinsurance

that

claim

classified into

Health

amount

thru amounts (i.e., capital-related costs, direct

education costs, kidney acquisition costs, bad debts);

any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under SNF PPS, SNFs will classify beneficiaries using

patient classification system known as RUGS III. For

SNF PPS claim, the SNF PRICER will calculate/return

for each revenue center line item with revenue center

'0022'; multiply the rate times the units count; and

sum the amount payable for all lines with revenue

code '0022' to determine the total claim payment

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each

group is the basis for determining the total payment.

Medicare payment amount takes into account the wage

adjustment and the beneficiary deductible and

amounts. NOTE: There is no CWF edit check to validate

the revenue center Medicare payment amount equals the

level Medicare payment amount.

Under Home Health PPS, beneficiaries will be

an appropriate case mix category known as the Home

Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment

first

mix

adjusted.

amount

adjustment

Although

provider will

encounter

contain

system

FFS,

actual

negotiated

services.

The

claims

appropriate to the HIPPS code by computing 60% (for

episode) or 50% (for subsequent episodes) of the case

episode payment. The payment is then wage index

For the final claim, PRICER calculates 100% of the

due, because the final claim is processed as an

to the RAP, reversing the RAP payment in full.

final claim will show 100% payment amount, the

actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA

data, the amount reported in this field may not just
represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims

amount paid to the provider, except that special
'differentials' paid outside the normal payment

are not included.

For demo Ids '05','15' -- encounter data 'claims'
contain amount Medicare would have paid under

instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain

provider payment but represent a special

bundled payment for both Part A and Part B

To identify what the conventional provider Part A
payment would have been, check value code = 'Y4'.

related noninstitutional (physician/supplier)

no

contain

instead of

contain what would have been paid had there been

demo.

For BBA encounter data (non-demo) -- 'claims'

amount Medicare would have paid under FFS,

the actual payment to the BBA plan.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: CLM_PMT_AMT
SAS ALIAS: PMT_AMT
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
+9(9).99

S9(7)V99. Als

as a l

claim lev

has be

COMMENT:
Prior to Version H the size of this field was

the noninstitutional claim records carried this field

item. Effective with Version H, this element is a

field across all claim types (and the line item field

renamed.)

SOURCE:
CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and
physician/supplier claims containing a
CLM_DISP_CD of '02', the amount shown as the Medicare
reimbursement does not take into consideration
any CWF automatic adjustments (involving erroneous
deductibles in most cases). In as many as 30% of
the claims (30% IP, 15% OP, 5% PART B), the
reimbursement reported on the claims may be over
or under the actual Medicare payment amount.

29. Claim Principal Diagnosis Code	CHAR	5	147	151	The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided. NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer. DB2 ALIAS: PRNCPAL_DGNS_CD SAS ALIAS: PDGNS_CD STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD TITLE ALIAS: PRINCIPAL_DIAGNOSIS EDIT-RULES: ICD-9-CM SOURCE: CWF
30. Claim Through Date	NUM	8	152	159	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date'). For the ENCRYPTED Standard View of the Carrier files, the claim through date is coded as the quarter of the calendar year when the claim through date occurred. NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_THRU_DT SAS ALIAS: THRU_DT STANDARD ALIAS: CLM_THRU_DT TITLE ALIAS: THRU_DATE EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.

						1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR SOURCE: CWF
31.	CWF Beneficiary Medicare Status Code	CHAR	2	160	161	The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT). COBOL ALIAS: MSC COMMON ALIAS: MSC DB2 ALIAS: BENE_MDCR_STUS_CD SAS ALIAS: MS_CD STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD SYSTEM ALIAS: LTMSC TITLE ALIAS: MSC DERIVATION: CWF derives MSC from the following: 1. Date of Birth 2. Claim Through Date 3. Original/Current Reasons for entitlement 4. ESRD Indicator 5. Beneficiary Claim Number Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

CODES:
10 = Aged without ESRD
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD only

						COMMENT: Prior to Version H this field was named: BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD). SOURCE: CWF
32.	NCH Carrier Claim Allowed Charge Amount	CHAR	13	162	174	Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges). NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 9.2 DIGITS SIGNED DB2 ALIAS: CARR_ALOW_CHRG_AMT SAS ALIAS: ALOWCHRG STANDARD ALIAS: NCH_CARR_ALOW_CHRG_AMT TITLE ALIAS: ALOW_CHRG EDIT-RULES: +9(9).99 SOURCE: NCH QA Process
33.	NCH Carrier Claim Submitted Charge Amount	CHAR	13	175	187	Effective with Version H, the total submitted charges on the claim (the sum of line item submitted charges). NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 9.2 DIGITS SIGNED DB2 ALIAS: CARR_SBMT_CHRG_AMT SAS ALIAS: SBMTCHRG STANDARD ALIAS: NCH_CARR_SBMT_CHRG_AMT TITLE ALIAS: SBMT_CHRG EDIT-RULES:

						+9(9).99 SOURCE: NCH QA Process
34.	NCH Claim Beneficiary Payment Amount	CHAR	13	188	200	Effective with Version H, the total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: NCH_BENE_PMT_AMT SAS ALIAS: BENE_PMT STANDARD ALIAS: NCH_CLM_BENE_PMT_AMT TITLE ALIAS: BENE_PMT EDIT-RULES: +9(9).99 SOURCE: NCH QA Process
35.	NCH Claim Provider Payment Amount	CHAR	13	201	213	Effective with Version H, the total payments made to the provider for this claim (sum of line item provider payment amounts.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: NCH_PRVDR_PMT_AMT SAS ALIAS: PROV_PMT STANDARD ALIAS: NCH_CLM_PRVDR_PMT_AMT TITLE ALIAS: PRVDR_PMT EDIT-RULES: +9(9).99 SOURCE:

NCH QA Process

36. NCH Near Line Record Identification Code — CHAR 1 214 214 — A code defining the type of claim record being processed.

COMMON ALIAS: RIC
DB2 ALIAS: NEAR_LINE_RIC_CD
SAS ALIAS: RIC_CD
STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD
TITLE ALIAS: RIC

CODES:
REFER TO: NCH_NEAR_LINE_RIC_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
RIC CD.

SOURCE:
NCH

37. NCH Near-Line Record Version Code — CHAR 1 215 215 — The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.

DB2 ALIAS: NCH_REC_VRSN_CD
SAS ALIAS: REC_LVL
STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD
TITLE ALIAS: NCH_VERSION

CODES:
A = Record format as of January 1991
B = Record format as of April 1991
C = Record format as of May 1991
D = Record format as of January 1992
E = Record format as of March 1992
F = Record format as of May 1992
G = Record format as of October 1993
H = Record format as of September 1998
I = Record format as of July 2000

COMMENT:
Prior to Version H this field was named:

CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE:
NCH

****

C L A I M D I A G N O S I S G R O U P R E C O R D

****

*** FI Carrier Claim Diagnosis Group Record - Encrypted Standard View

GROUP 26

Claim Diagnosis Group Record for the Encrypted Standard View of the Carrier version I NCH Nearline File.

The number of claim diagnosis trailers is determined by the claim diagnosis code count.
The principal diagnosis is the first occurrence.
The 'E' code (ICD-9-CM code for the external cause of an injury, poisoning, or adverse affect) is stored as the last occurrence.
The principal diagnosis and the 'E' code are also stored (redundantly) in the fixed record.

NOTE:
Prior to Version H this group was named:
CLM_OTHR_DGNS_GRP and did not contain the CLM_PRNCPAL_DGNS_CD.

OCCURS: UP TO 10 TIMES
DEPENDING ON CARR_CLM_DGNS_CD_CNT.

STANDARD ALIAS: UTLCARRI_CARR_CLM_DGNS_GRP

1. Record Length Count	NUM	5	1	5	Effective with Version H, the count (in bytes) of the length of the Claim Diagnosis Group Record. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT

					SOURCE: NCH
2. Record Number	NUM	9	6	14	An automatically assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Claim Header Data 01 = Carrier Line Data 02 = Claim Demonstration ID Data 03 = Claim Diagnosis Data 04 = Claim Health PlanID Data 05 = Claim Occurrence Span Data 06 = Claim Procedure Data 07 = Claim Related Condition Data 08 = Claim Related Occurrence Data 09 = Claim Value Data 10 = MCO Period Data 11 = NCH Edit Data 12 = NCH Patch Data 13 = DMERC Line Data 14 = Revenue Center Data
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim. STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to

service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient

encounters

(available in NMUD) have also been added.

STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
  NCH CLM_NEAR_LINE_RIC_CD
  NCH PMT_EDIT_RIC_CD
  NCH CLM_TRANS_CD
  NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (Pre-HDC processing -- AVAILABLE IN NCH)
  CLM_MCO_PD_SW
  CLM_RLT_COND_CD
  MCO_CNTRCT_NUM
  MCO_OPTN_CD
  MCO_PRD_EFCTV_DT
  MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD
NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  CARR_NUM
  CLM_DEMO_ID_NUM

```
OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM:  (AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

DERIVATION RULES:

  SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
  FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
  2.   PMT_EDIT_RIC_CD EQUAL 'F'
  3.   CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '0' OR '4'
4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
     OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '0' OR '4'
4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
     OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
3.   CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
```

```
3.   CLM_TRANS_CD EQUAL '6'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1.   FI_NUM = 80881
2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
     CLSFCTN_TYPE_CD = '2', '3' OR '4' &
     CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'I'
3.   CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_MCO_PD_SW = '1'
2.   CLM_RLT_COND_CD = '04'
3.   MCO_CNTRCT_NUM
     MCO_OPTN_CD = 'C'
     CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
     MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
     ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
```

TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

6. Claim Diagnosis Code	CHAR	5	22	26	The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code). NOTE: Prior to Version H, the principal diagnosis

code was not stored with the 'OTHER' diagnosis
codes. During the Version H conversion the
CLM_PRNCPAL_DGNS_CD was added as the first
occurrence.

DB2 ALIAS: CLM_DGNS_CD
SAS ALIAS: DGNS_CD
STANDARD ALIAS: CLM_DGNS_CD
TITLE ALIAS: DIAGNOSIS

EDIT-RULES:
ICD-9-CM

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD.

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C L A I M L I N E G R O U P R E C O R D

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***	FI Carrier Claim Line Group Record - Encrypted Standard View	GROUP	302			Claim Line Group Record for the Encrypted Standard View of the Carrier version I NCH Nearline File. The number of line item trailers is determined by the line item count. Effective with Version 'I', this group was added to the carrier and DMERC records to keep fields common across all record types in the same position. Due to OP PPS, several fields on the Institutional record had to be moved to a link group so those same fields had to be moved on the carrier records eventhough OP PPS only affects institutional claims. OCCURS: UP TO 13 TIMES DEPENDING ON CARR_CLM_LINE_CNT. STANDARD ALIAS: UTLCARRI_CARR_CLM_LINE_GRP
1.	Record Length Count	NUM	5	1	5	Effective with Version H, the count (in bytes)

					of the length of the Claim Diagnosis Group Record. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT SOURCE: NCH
2. Record Number	NUM	9	6	14	An automatically assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Claim Header Data 01 = Carrier Line Data 02 = Claim Demonstration ID Data 03 = Claim Diagnosis Data 04 = Claim Health PlanID Data 05 = Claim Occurrence Span Data 06 = Claim Procedure Data 07 = Claim Related Condition Data 08 = Claim Related Occurrence Data 09 = Claim Value Data 10 = MCO Period Data 11 = NCH Edit Data 12 = NCH Patch Data 13 = DMERC Line Data 14 = Revenue Center Data
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.

					STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991). NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added. STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD

```
  CLM_FREQ_CD
NOTE:  From 7/1/97 to the start of HDC processing(?),
abbreviated inpatient encounter claims are not
available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  CARR_NUM
  CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM:  (AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

DERIVATION RULES:

  SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
  FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
  2.   PMT_EDIT_RIC_CD EQUAL 'F'
  3.   CLM_TRANS_CD EQUAL '5'

  SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
```

```
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
3.   CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
3.   CLM_TRANS_CD EQUAL '6'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1.   FI_NUM = 80881
2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
     CLSFCTN_TYPE_CD = '2', '3' OR '4' &
     CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'I'
3.   CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_MCO_PD_SW = '1'
2.   CLM_RLT_COND_CD = '04'
3.   MCO_CNTRCT_NUM
     MCO_OPTN_CD = 'C'
     CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
     MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
     ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
```

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_ TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

						SOURCE: NCH
6.	Carrier Line Performing PIN Number	CHAR	10	22	31	The profiling identification number (PIN) of the physician\supplier who performed the service for this line item on the carrier claim (non-DMERC). This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier file. COMMON ALIAS: PHYSICIAN/SUPPLIER_PROVIDER_NUM DB2 ALIAS: LINE_PRFRMG_PIN SAS ALIAS: PRF_PRFL STANDARD ALIAS: CARR_LINE_PRFRMG_PIN_NUM TITLE ALIAS: PRFRMG_PIN COMMENT: Prior to Version H this field was named: CWFB_PRFRMG_PRVDR_PRFLG_NUM. SOURCE: CWF
7.	Carrier Line Performing UPIN Number	CHAR	6	32	37	The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC). This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier file. DB2 ALIAS: LINE_PRFRMG_UPIN SAS ALIAS: PRF_UPIN STANDARD ALIAS: CARR_LINE_PRFRMG_UPIN_NUM TITLE ALIAS: PRFRMG_UPIN COMMENT: Prior to Version H this field was named: CWFB_PRFRMG_PRVDR_UPIN_NUM. SOURCE: CWF
8.	Line NCH Provider State	CHAR	2	38	39	Effective with Version H, the two position

	Code					SSA state code where provider facility is located. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS: LINE_PRVDR_STATE SAS ALIAS: PRVSTATE STANDARD ALIAS: LINE_NCH_PRVDR_STATE_CD TITLE ALIAS: PRVDR_STATE DERIVATION: DERIVED FROM: CARR_LINE_PRFRMG_PRVDR_ZIP_CD DERIVATION RULES: Use the first three positions of the provider zip code to derive the LINE_NCH_PRVDR_STATE_CD from a crosswalk file. Where a match is not achieved this field will be blank. CODES: REFER TO: GEO_SSA_STATE_TB SOURCE: NCH
9.	Line HCFA Provider Specialty Code	CHAR	2	40	41	HCFA specialty code used for pricing the line item service on the noninstitutional claim. DB2 ALIAS: HCFA_SPCLTY_CD SAS ALIAS: HCFASPCL STANDARD ALIAS: LINE_HCFA_PRVDR_SPCLTY_CD TITLE ALIAS: HCFA_PRVDR_SPCLTY CODES: REFER TO: HCFA_PRVDR_SPCLTY_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_HCFA_PRVDR_SPCLTY_CD.

						SOURCE: CWF
10.	Line Provider Participating Indicator Code	CHAR	1	42	42	Code indicating whether or not a provider is participating or accepting assignment for this line item service on the noninstitutional claim. DB2 ALIAS: PRVDR_PRTCPTG_CD SAS ALIAS: PRTCPTG STANDARD ALIAS: LINE_PRVDR_PRTCPTG_IND_CD TITLE ALIAS: PRVDR_PRTCPTG_IND CODES: REFER TO: LINE_PRVDR_PRTCPTG_IND_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_PRVDR_PRTCPTG_IND_CD. SOURCE: CWF
11.	Carrier Line Reduced Payment Physician Assistant Code	CHAR	1	43	43	Effective 1/92, the code on the carrier (non-DMERC) line item that identifies claims that have been paid a reduced fee schedule amount (65%, 75% or 85%) because a physician's assistant performed the services. COMMON ALIAS: PA_65/75/85%_FEE DB2 ALIAS: PHYSN_ASTNT_CD SAS ALIAS: ASTNT_CD STANDARD ALIAS: CARR_LINE_RDCD_PHYSN_ASTNT_CD TITLE ALIAS: PHYSN_ASTNT_CD CODES: REFER TO: CARR_LINE_RDCD_PHYSN_ASTNT_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_RDCD_PMT_PHYSN_ASTNT_CD. SOURCE: CWF

12. Line Service Count	CHAR	4	44	47	The count of the total number of services processed for the line item on the non-institutional claim. 3 DIGITS SIGNED DB2 ALIAS: SRVC_CNT SAS ALIAS: SRVC_CNT STANDARD ALIAS: LINE_SRVC_CNT EDIT-RULES: +999 COMMENT: Prior to Version H this field was named: CWFB_SRVC_CNT. SOURCE: CWF
13. Line HCFA Type Service Code	CHAR	1	48	48	Code indicating the type of service, as defined in the HCFA Medicare Carrier Manual, for this line item on the non-institutional claim. DB2 ALIAS: HCFA_TYPE_SRVC_CD SAS ALIAS: TYPSRVCB STANDARD ALIAS: LINE_HCFA_TYPE_SRVC_CD SYSTEM ALIAS: LTTOS TITLE ALIAS: HCFA_TYPE_SRVC EDIT-RULES: The only type of service codes applicable to DMERC claims are: 1, 9, A, E, G, H, J, K, L, M, P, R, and S. CODES: REFER TO: HCFA_TYPE_SRVC_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_HCFA_TYPE_SRVC_CD. SOURCE: CWF

14. Line Place Of Service Code	CHAR	2	49	50	The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the noninstitutional claim. COMMON ALIAS: POS DB2 ALIAS: LINE_PLC_SRVC_CD SAS ALIAS: PLCSRVC STANDARD ALIAS: LINE_PLC_SRVC_CD TITLE ALIAS: PLC_SRVC CODES: REFER TO: LINE_PLC_SRVC_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_PLC_SRVC_CD. SOURCE: CWF
15. Carrier Line Pricing Locality Code	CHAR	2			Code denoting the carrier-specific locality used for pricing the service for this line item on the carrier claim (non-DMERC). DB2 ALIAS: PRCNG_LCLTY_CD SAS ALIAS: LCLTY_CD STANDARD ALIAS: CARR_LINE_PRCNG_LCLTY_CD TITLE ALIAS: PRICING_LOCALITY EDIT-RULES: CARRIER INFORMATION FILE COMMENT: Prior to Version H this field was named: CWFB_CARR_PRCNG_LCLTY_CD. SOURCE: CWF
16. Line Last Expense Date	NUM	8	53	60	The ending date (last expense) for the line item service on the noninstitutional claim. 8 DIGITS UNSIGNED COBOL ALIAS: LST_EXP_DT

DB2 ALIAS: LINE_LAST_EXPNS_DT
SAS ALIAS: EXPNSDT2
STANDARD ALIAS: LINE_LAST_EXPNS_DT
TITLE ALIAS: LAST_EXPNS_DT

EDIT-RULES FOR ENCRYPTED DATA:
YYYYQ000 WHERE Q IS ONE OF THE
FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

COMMENT:
Prior to Version H this field was named:
CWFB_LAST_EXPNS_DT.

SOURCE:
CWF

17. Line HCPCS Code	CHAR	5	61	65	The Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below: DB2 ALIAS: LINE_HCPCS_CD SAS ALIAS: HCPCS_CD STANDARD ALIAS: LINE_HCPCS_CD TITLE ALIAS: HCPCS_CD COMMENT: Prior to Version H this line item field was named: HCPCS_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE). Level I Codes and descriptors copyrighted by the American Medical Association's Current Procedural

Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

**** Note: ****
CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright.

Level II
Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

18. Line HCPCS Initial Modifier Code	CHAR	2	66	67	A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the noninstitutional claim.

DB2 ALIAS: HCPCS_1ST_MDFR_CD
SAS ALIAS: MDFR_CD1
STANDARD ALIAS: LINE_HCPCS_INITL_MDFR_CD
TITLE ALIAS: INITIAL_MODIFIER

EDIT-RULES:

					CARRIER INFORMATION FILE COMMENT: Prior to Version H this field was named: HCPCS_INITL_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE). SOURCE: CWF
19. Line HCPCS Second Modifier Code	CHAR	2	68	69	A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim. DB2 ALIAS: HCPCS_2ND_MDFR_CD SAS ALIAS: MDFR_CD2 STANDARD ALIAS: LINE_HCPCS_2ND_MDFR_CD TITLE ALIAS: SECOND_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE COMMENT: Prior to Version H this field was named: HCPCS_2ND_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE). SOURCE: CWF
20. Line NCH BETOS Code	CHAR	3	70	72	Effective with Version H, the Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. This field is included as a line item on the noninstitutional claim. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS: LINE_NCH_BETOS_CD
SAS ALIAS: BETOS
STANDARD ALIAS: LINE_NCH_BETOS_CD
SYSTEM ALIAS: LTBETOS
TITLE ALIAS: BETOS

DERIVATION:
DERIVED FROM:
   LINE_HCPCS_CD
   LINE_HCPCS_INITL_MDFR_CD
   LINE_HCPCS_2ND_MDFR_CD
   HCPCS MASTER FILE

DERIVATION RULES:
Match the HCPCS on the claim to the HCPCS on
the HCPCS Master File to obtain the BETOS code.

CODES:
  REFER TO: BETOS_TB
            IN THE CODES APPENDIX

SOURCE:
NCH

21. Line IDE Number	CHAR	7	73	79	Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. NOTE: Prior to Version H a dummy line item was created in the last occurrence of line item group to store IDE. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There will be only one distinct IDE number reported on the non-institutional claim. During the Version H conversion, the IDE was moved from the dummy line item to its own dedicated field for each line item (i.e., the IDE was repeated on all line items on the claim.)

					DB2 ALIAS: LINE_IDE_NUM SAS ALIAS: LINE_IDE STANDARD ALIAS: LINE_IDE_NUM TITLE ALIAS: IDE_NUMBER SOURCE: CWF
22. Line National Drug Code	CHAR	11	80	90	Effective 1/1/94 on the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs. Effective with Version H, this line item field was added as a placeholder on the carrier claim. DB2 ALIAS: LINE_NATL_DRUG_CD SAS ALIAS: NDC_CD STANDARD ALIAS: LINE_NATL_DRUG_CD TITLE ALIAS: NDC_CD SOURCE: CWF
23. Line NCH Payment Amount	CHAR	13	91	103	Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim. 9.2 DIGITS SIGNED COMMON ALIAS: REIMBURSEMENT DB2 ALIAS: LINE_NCH_PMT_AMT SAS ALIAS: LINEPMT STANDARD ALIAS: LINE_NCH_PMT_AMT TITLE ALIAS: REIMBURSEMENT EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this line item field was named: CLM_PMT_AMT and the size of this field was S9(7)V99. SOURCE: NCH
24. Line Beneficiary Payment	CHAR	13	104	116	Effective with Version H, the payment (reim-

Amount					bursement) made to the beneficiary related to the line item service on the noninstitutional claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_BENE_PMT_AMT SAS ALIAS: LBENPMT STANDARD ALIAS: LINE_BENE_PMT_AMT TITLE ALIAS: BENE_PMT_AMT EDIT-RULES: +9(9).99 SOURCE: CWF
25.	Line Provider Payment Amount	CHAR	13	117 129	Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_PRVDR_PMT_AMT SAS ALIAS: LPRVPMT STANDARD ALIAS: LINE_PRVDR_PMT_AMT TITLE ALIAS: PRVDR_PMT_AMT EDIT-RULES: +9(9).99 SOURCE: CWF
26.	Line Beneficiary Part B Deductible Amount	CHAR	13	130 142	The amount of money for which the carrier has determined that the beneficiary

						is liable for the Part B cash deductible for the line item service on the noninstitutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_DDCTBL_AMT SAS ALIAS: LDEDAMT STANDARD ALIAS: LINE_BENE_PTB_DDCTBL_AMT TITLE ALIAS: PTB_DED_AMT EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: BENE_PTB_DDCTBL_LBLTY_AMT and the size of the field was S9(3)V99. SOURCE: CWF
27.	Line Beneficiary Primary Payer Code	CHAR	1	143	143	The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the noninstitutional claim. DB2 ALIAS: LINE_PRMRY_PYR_CD SAS ALIAS: LPRPAYCD STANDARD ALIAS: LINE_BENE_PRMRY_PYR_CD TITLE ALIAS: PRIMARY_PAYER_CD CODES: REFER TO: BENE_PRMRY_PYR_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CD. SOURCE: CWF,VA,DOL,SSA
28.	Line Beneficiary Primary Payer Paid Amount	CHAR	13	144	156	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other

					than Medicare, that the provider is applying to covered Medicare charges for to the line ITEM SERVICE ON THE NONINSTITUTIONAL. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_PRMRY_PYR_PD SAS ALIAS: LPRPDAMT STANDARD ALIAS: LINE_BENE_PRMRY_PYR_PD_AMT TITLE ALIAS: PRMRY_PYR_PD EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_PMT_AMT and the field size was S9(5)V99. SOURCE: CWF
29. Line Coinsurance Amount	CHAR	13	157	169	Effective with Version H, the beneficiary coinsurance liability amount for this line item service on the noninstitutional claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_COINSRNC_AMT SAS ALIAS: COINAMT STANDARD ALIAS: LINE_COINSRNC_AMT TITLE ALIAS: COINSRNC_AMT EDIT-RULES: +9(9).99 SOURCE: CWF
30. Carrier Line Psychiatric, Occupational Therapy,	CHAR	13	170	182	For type of service psychiatric, occupational therapy or physical therapy, the amount of

	Physical Therapy Limit Amount					allowed charges applied toward the limit cap for this line item service on the noninstitutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: PSYCH_OT_PT_LMT SAS ALIAS: LLMTAMT STANDARD ALIAS: CARR_LINE_PSYCH_OT_PT_LMT_AMT TITLE ALIAS: PSYCH_OT_PT_LIMIT EDIT-CODES: +9(9).99 COMMENT: Prior to Version H this field was named: CWFB_PSYCH_OT_PT_LMT_AMT and the field size was S9(5)V99. SOURCE: CWF
31.	Line Interest Amount	CHAR	13	183	195	Amount of interest to be paid for this line item service on the noninstitutional claim. **NOTE: This is not included in the line item NCH payment (reimbursement) amount. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_INTRST_AMT SAS ALIAS: LINT_AMT STANDARD ALIAS: LINE_INTRST_AMT TITLE ALIAS: INTRST_AMT EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: CWFB_INTRST_AMT and the field size was S9(5)V99. SOURCE: CWF
32.	Line Primary Payer Allowed	CHAR	13	196	208	Effective with Version H, the primary payer

	Charge Amount					allowed charge amount for the line item service on the noninstitutional claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: PRMRY_PYR_ALOW_AMT SAS ALIAS: PRPYALOW STANDARD ALIAS: LINE_PRMRY_PYR_ALOW_CHRG_AMT TITLE ALIAS: PRMRY_PYR_ALOW_CHRG EDIT-RULES: +9(9).99 SOURCE: CWF
33.	Line 10% Penalty Reduction Amount	CHAR	13	209	221	Effective with Version H, the 10% payment reduction amount (applicable to a late filing claim) for the line item service. on the noninstitutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: TENPCT_PNLTY_AMT SAS ALIAS: PNLTYAMT STANDARD ALIAS: LINE_10PCT_PNLTY_RDCTN_AMT TITLE ALIAS: TENPCT_PNLTY EDIT-RULES: +9(9).99 SOURCE: CWF
34.	Carrier Line Blood Deductible Pints Quantity	CHAR	4	222	225	The blood pints quantity (deductible) for the line item on the carrier claim (non-DMERC). 3 DIGITS SIGNED DB2 ALIAS: LINE_BLOOD_DDCTBL SAS ALIAS: LBLD_DED

						STANDARD ALIAS: CARR_LINE_BLOOD_DDCTBL_QTY TITLE ALIAS: BLOOD_DDCTBL EDIT-RULES: +999 COMMENT: Prior to Version H this field was named: CWFB_LINE_BLOOD_DDCTBL_QTY. SOURCE: CWF
35.	Line Submitted Charge Amount	CHAR	13	226	238	The amount of submitted charges for the line item service on the noninstitutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_SBMT_CHRG_AMT SAS ALIAS: LSBMTCHG STANDARD ALIAS: LINE_SBMT_CHRG_AMT TITLE ALIAS: SBMT_CHRG EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: CWFB_SBMT_CHRG_AMT and the field size was S9(5)V99. SOURCE: CWF
36.	Line Allowed Charge Amount	CHAR	13	239	251	The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. **NOTE: The allowed charge is determined by the lower of three charges: prevailing, customary or actual. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_ALOW_CHRG_AMT SAS ALIAS: LALOWCHG STANDARD ALIAS: LINE_ALOW_CHRG_AMT

						TITLE ALIAS: ALOW_CHRG EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: CWFB_ALOW_CHRG_AMT and the field size was S9(5)V99. SOURCE: CWF
37.	Carrier Line Clinical Lab Number	CHAR	10	252	261	The identification number assigned to the clinical laboratory providing services for the line item on the carrier claim (non-DMERC). DB2 ALIAS: CLNCL LAB NUM SAS ALIAS: LAB_NUM STANDARD ALIAS: CARR_LINE_CLNCL_LAB_NUM TITLE ALIAS: LAB_NUM COMMENT: Prior to Version H this field was named: CWFB_CLNCL_LAB_NUM. SOURCE: CWF
38.	Carrier Line Clinical Lab Charge Amount	CHAR	13	262	274	Fee schedule charge amount applied for the line item clinical laboratory service on the carrier claim (non-DMERC). 9.2 DIGITS SIGNED DB2 ALIAS: CLNCL_LAB_CHRG_AMT SAS ALIAS: LAB_AMT STANDARD ALIAS: CARR_LINE_CLNCL_LAB_CHRG_AMT TITLE ALIAS: LAB_CHRG EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: CWFB_CLNCL_LAB_CHRG_AMT and the field size was

						S9(5)V99. SOURCE: CWF
39.	Line Processing Indicator Code	CHAR	1	275	275	The code indicating the reason a line item on the noninstitutional claim was allowed or denied. DB2 ALIAS: LINE_PRCSG_IND_CD SAS ALIAS: PRCNGIND STANDARD ALIAS: LINE_PRCSG_IND_CD TITLE ALIAS: PRCSG_IND CODES: REFER TO: LINE_PRCSG_IND_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_PRCSG_IND_CD. SOURCE: CWF
40.	Line Payment 80%/100% Code	CHAR	1	276	276	The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only. COMMON ALIAS: REIMBURSEMENT_IND DB2 ALIAS: LINE_PMT_80_100_CD SAS ALIAS: PMTINDSW STANDARD ALIAS: LINE_PMT_80_100_CD TITLE ALIAS: REINBURSEMENT_IND CODES: 0 = 80% 1 = 100% 3 = 100% Limitation of liability only COMMENT: Prior to Version H this field was named: CWFB_PMT_80_100_CD.

						SOURCE: CWF
41.	Line Service Deductible Indicator Switch	CHAR	1	277	277	Switch indicating whether or not the line item service on the noninstitutional claim is subject to a deductible. DB2 ALIAS: SRVC_DDCTBL_SW SAS ALIAS: DED_SW STANDARD ALIAS: LINE_SRVC_DDCTBL_IND_SW TITLE ALIAS: SRVC_DED_IND CODES: 0 = Service subject to deductible 1 = Service not subject to deductible COMMENT: Prior to Version H this field was named: CWFB_SRVC_DDCTBL_IND_SW. SOURCE: CWF
42.	Line Payment Indicator Code	CHAR	1	278	278	Code that indicates the payment screen used to determine the allowed charge for the line item service on the noninstitutional claim. DB2 ALIAS: LINE_PMT_IND_CD SAS ALIAS: PMTINDCD STANDARD ALIAS: LINE_PMT_IND_CD TITLE ALIAS: PMT_IND CODES: REFER TO: LINE_PMT_IND_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_PMT_IND_CD. SOURCE: CWF
43.	Carrier Line Miles/Time/Units/Services Count	CHAR	4	279	282	The count of the total units associated with services needing unit reporting such as transportation, miles, anesthesia time units,

number of services, volume of oxygen or blood units. This is a line item field on the carrier claim (non-DMERC) and is used for both allowed and denied services.

3 DIGITS SIGNED

DB2 ALIAS: LINE_MTUS_CNT
SAS ALIAS: MTUS_CNT
STANDARD ALIAS: CARR_LINE_MTUS_CNT
TITLE ALIAS: MTUS_CNT

EDIT-RULES:
+999

For CARR_LINE_MTUS_IND_CD equal to 2 (anesthesia time units) there is one implied decimal point.

COMMENT:
Prior to Version H this field was named: CWFB_MTUS_CNT.

SOURCE:
CWF

44.	Carrier Line Miles/Time/Units/Services Indicator Code	CHAR	1	283	283	Code indicating the units associated with services needing unit reporting on the line item for the carrier claim (non-DMERC).

DB2 ALIAS: LINE_MTUS_IND_CD
SAS ALIAS: MTUS_IND
STANDARD ALIAS: CARR_LINE_MTUS_IND_CD
TITLE ALIAS: MTUS_IND

CODES:
0 = Values reported as zero (no allowed activities)
1 = Transportation (ambulance) miles
2 = Anesthesia time units
3 = Services
4 = Oxygen units
5 = Units of blood
6 = Anesthesia base and time units (prior to 1991; from BMAD)

COMMENT:

					Prior to Version H this field was named: CWFB_MTUS_IND_CD. SOURCE: CWF
45. Line Diagnosis Code	CHAR	5	284	288	The ICD-9-CM code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim. DB2 ALIAS: LINE_DGNS_CD SAS ALIAS: LINEDGNS STANDARD ALIAS: LINE_DGNS_CD TITLE ALIAS: DGNS_CD EDIT-RULES: ICD-9-CM COMMENT: Prior to Version H this field was named: CWFB_LINE_DGNS_CD. SOURCE: CWF
46. Carrier Line CLIA Alert Indicator Code	CHAR	1	289	289	Effective with Version G, the alert code (resulting from CLIA editing) added by CWF as a line item on the carrier claim (non-DMERC). DB2 ALIAS: CLIA_ALERT_IND_CD SAS ALIAS: CLIAALRT STANDARD ALIAS: CARR_LINE_CLIA_ALERT_IND_CD TITLE ALIAS: CLIA_ALERT CODES: (Effective 9/92 but not stored until 10/93) 0 = No Alert 1 = 77X9 2 = 77XA 3 = 77X5 4 = 77X6 5 = 77X7 6 = 77X8 7 = 77XB COMMENT:

						Prior to Version H this field was named: CWFB_CLIA_ALERT_IND_CD. SOURCE: CWF
47.	Line DME Purchase Price Amount	CHAR	13	290	302	Effective 5/92, the amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the cap is met. This line item field is applicable to non-institutional claims involving DME, prosthetic, orthotic and supply items, immunosuppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS. 9.2 DIGITS SIGNED DB2 ALIAS: DME_PURC_PRICE_AMT SAS ALIAS: DME_PURC STANDARD ALIAS: LINE_DME_PURC_PRICE_AMT TITLE ALIAS: DME_PURC_PRICE EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: CWFB_DME_PURC_PRICE_AMT and the field size was S9(5)V99. SOURCE: CWF

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant
B = Aged wife, age 62 or over (1st claimant)
B1 = Aged husband, age 62 or over (1st claimant)

B2 = Young wife, with a child in her care
(1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st
claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9,CA-CZ = Child (includes minor, student
or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st
claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of
age 60) (1st claimant)
D5 = Widower (remarried after attainment of
age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over
(1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)

DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower) (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)

EK = Surviving divorced father (4th
claimant)
EM = Surviving divorced father (5th
claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB
(less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB
(over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB
(less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB

(over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than
3 Q.C.) (general fund) (1st claimant)
K2 = Prouty wife entitled to HIB (over 2
Q.C.) (RSI trust fund) (1st claimant)
K3 = Prouty wife not entitled to HIB (less
than 3 Q.C.) (general fund) (1st
claimant)
K4 = Prouty wife not entitled to HIB (over
2 Q.C.) (RSI trust fund) (1st
claimant)
K5 = Prouty wife entitled to HIB (less than
3 Q.C.) (general fund) (2nd claimant)
K6 = Prouty wife entitled to HIB (over 2
Q.C.) (RSI trust fund) (2nd claimant)
K7 = Prouty wife not entitled to HIB (less
than 3 Q.C.) (general fund) (2nd
claimant)
K8 = Prouty wife not entitled to HIB (over
2 Q.C.) (RSI trust fund) (2nd
claimant)
K9 = Prouty wife entitled to HIB (less than
3 Q.C.) (general fund) (3rd claimant)
KA = Prouty wife entitled to HIB (over 2

Q.C.) (RSI trust fund) (3rd claimant)
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C (4th claimant)
KF = Prouty wife not entitled to HIB (less than 3 Q.C.)(4th claimant)
KG = Prouty wife not entitled to HIB (over 2 Q.C.)(4th claimant)
KH = Prouty wife entitled to HIB (less than 3 Q.C.)(5th claimant)
KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less than 3 Q.C.)(5th claimant)
KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)
M = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured-entitled to HIB under deemed or renal provisions
TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)

1	BENE_IDENT_TB	Beneficiary Identification Code (BIC) Table
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TH = MQGE aged spouse (third claimant)
TJ = MQGE aged spouse (fourth claimant)
TK = MQGE aged spouse (fifth claimant)
TL = MQGE aged widow(er) (second claimant)
TM = MQGE aged widow(er) (third claimant)
TN = MQGE aged widow(er) (fourth claimant)
TP = MQGE aged widow(er) (fifth claimant)
TQ = MQGE parent (female)
TR = MQGE young widow(er) (second claimant)

TS = MQGE young widow(er) (third claimant)
TT = MQGE young widow(er) (fourth claimant)
TU = MQGE young widow(er) (fifth claimant)
TV = MQGE disabled widow(er) fifth claimant
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth claimant)
W = Disabled widow, age 50 or over (1st claimant)
W1 = Disabled widower, age 50 or over (1st claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st claimant)
W7 = Disabled surviving divorced wife (2nd claimant)
W8 = Disabled surviving divorced wife (3rd claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th claimant)
WR = Disabled surviving divorced husband (1st claimant)
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

NOTE:
Employee: a Medicare beneficiary who is still working or a worker who died before retirement
Annuitant: a person who retired under the railroad retirement act on or after 03/01/37

Pensioner: a person who retired prior to
03/01/37 and was included in the
railroad retirement act

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

10 = Retirement - employee or annuitant
80 = RR pensioner (age or disability)
14 = Spouse of RR employee or annuitant
(husband or wife)
84 = Spouse of RR pensioner
43 = Child of RR employee
13 = Child of RR annuitant
17 = Disabled adult child of RR annuitant
46 = Widow/widower of RR employee
16 = Widow/widower of RR annuitant
86 = Widow/widower of RR pensioner
43 = Widow of employee with a child in her care
13 = Widow of annuitant with a child in her care
83 = Widow of pensioner with a child in her care
45 = Parent of employee
15 = Parent of annuitant
85 = Parent of pensioner
11 = Survivor joint annuitant
(reduced benefits taken to insure benefits
for surviving spouse)

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

A = Working aged bene/spouse with employer
group health plan (EGHP)
B = End stage renal disease (ESRD) beneficiary
in the 18 month coordination period with
an employer group health plan
C = Conditional payment by Medicare; future
reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior
to 3/94, also included any liability
insurance)
E = Workers' compensation
F = Public Health Service or other federal
agency (other than Dept. of Veterans
Affairs)

G = Working disabled bene (under age 65
    with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance
    (eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97)
    (eff. 12/90 for carrier claims and 10/93
    for FI claims; obsoleted for all claim
    types 7/1/96)

M = Override code: EGHP services involved
    (eff. 12/90 for carrier claims and 10/93
    for FI claims; obsoleted for all claim
    types 7/1/96)

N = Override code: non-EGHP services involved
    (eff. 12/90 for carrier claims and 10/93
    for FI claims; obsoleted for all claim
    types 7/1/96)

BLANK = Medicare is primary payer (not sure
        of effective date: in use 1/91, if
        not earlier)

T = MSP cost avoided - IEQ contractor
    (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjust-
    ment contractor (eff. 7/96 carrier claims
    only)
V = MSP cost avoided - litigation settlement
    contractor (eff. 7/96 carrier claims
    only)

X = MSP cost avoided override code (eff.
    12/90 for carrier claims and 10/93 for
    FI claims; obsoleted for all claim types
    7/1/96)

Prior to 12/90

Y = Other secondary payer investigation
    shows Medicare as primary payer

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK
indicate Medicare is primary payer.
(values Z and Y were used prior to
12/90. BLANK was suppose to be
effective after 12/90, but may have
been used prior to that date.)

1	BETOS_TB	BETOS Table
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M1A = Office visits - new
M1B = Office visits - established
M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - opthamology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterctomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion

P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services

1 BETOS_TB BETOS Table

I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT: head
I2B = Advanced imaging - CAT: other
I2C = Advanced imaging - MRI: brain
I2D = Advanced imaging - MRI: other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries
I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac catheter
I4B = Imaging/procedure - other

T1A = Lab tests - routine venipuncture (non Medicare
fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Orthotic devices
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Vision, hearing and speech services
O1G = Influenza immunization
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

1 CARR_CLM_PMT_DNL_TB Carrier Claim Payment Denial Table
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0 = Denied
1 = Physician/supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of

liability
B = Physician/supplier under limitation of liability
D = Denied due to demonstration involvement (eff. 5/97)
E = MSP cost avoided IRS/SSA/HCFA Data Match (eff. 7/3/00)
F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)
G = MSP cost avoided Litigation Settlement (eff. 7/3/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)

1 CARR_LINE_PRVDR_TYPE_TB — Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

0 = Clinics, groups, associations, partnerships, or other entities
1 = Physicians or suppliers reporting as solo practitioners
2 = Suppliers (other than sole proprietorship)
3 = Institutional provider
4 = Independent laboratories
5 = Clinics (multiple specialties)
6 = Groups (single specialty)
7 = Other entities

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

0 = Clinics, groups, associations,
    partnerships, or other entities
    for whom the carrier's own ID number
    has been assigned.
1 = Physicians or suppliers billing as
    solo practitioners for whom SSN's are
    shown in the physician ID code field.
2 = Physicians or suppliers billing as
    solo practitioners for whom the carrier's
    own physician ID code is shown.
3 = Suppliers (other than sole proprietorship)
    for whom EI numbers are used in coding the
    ID field.
4 = Suppliers (other than sole proprietorship)
    for whom the carrier's own code has been
    shown.
5 = Institutional providers and
    independent laboratories for whom EI
    numbers are used in coding the ID field.
6 = Institutional providers and
    independent laboratories for whom the
    carrier's own ID number is shown.
7 = Clinics, groups, associations, or
    partnerships for whom EI numbers
    are used in coding the ID field.
8 = Other entities for whom EI numbers
    are used in coding the ID field or
    proprietorship for whom EI numbers are
    used in coding the ID field.

1CARR_LINE_RDCD_PHYSN_ASTNT_TB

Carrier Line Part B Reduced Physician Assistant Table

BLANK = Adjustment situation (where
        CLM_DISP_CD equal 3)
0 = N/A
1 = 65%
    A) Physician assistants assisting in
       surgery
    B) Nurse midwives
2 = 75%
    A) Physician assistants performing

services in a hospital (other than assisting surgery)
B) Nurse practitioners and clinical nurse specialists performing services in rural areas
C) Clinical social worker services

3 = 85%
A) Physician assistant services for other than assisting surgery
B) Nurse practitioners services

1 CARR_NUM_TB — Carrier Number Table

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisianna - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)
00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995) (term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.) (eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)

00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
(eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
(eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;
term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)

00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)

01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)
(term. 2000)
03070 = Connecticut General Life Insurance Co.
(eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
(eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
(term. 1989)
05535 = North Carolina - Connecticut General
(eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983)
(term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
(term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
(term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
(term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
(term. 2000)
10555 = Travelers Insurance Co. (eff. 1993)
(term. 2000)
11260 = Missouri - General American Life
(eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.
31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.

31146 = So. California - NHIC (eff. 2000)

1 CLM_DISP_TB — Claim Disposition Table

01 = Debit accepted
02 = Debit accepted (automatic adjustment)
applicable through 4/4/93
03 = Cancel accepted
61 = *Conversion code: debit accepted
62 = *Conversion code: debit accepted
(automatic adjustment)
63 = *Conversion code: cancel accepted

*Used only during conversion period:
1/1/91 - 2/21/91

1 CTGRY_EQTBL_BENE_IDENT_TB — Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC	SSA Categories
A	A;J1;J2;J3;J4;M;M1;T;TA
B	B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;TB(F);TD(F);TE(F);TW(F)
B1	B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)TD(M);TE(M);TW(M)
B3	B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2W7;TG(F);TL(F);TR(F);TX(F)
B4	B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)TL(M);TR(M);TX(M)
B8	B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4W8;TH(F);TM(F);TS(F);TY(F)
BA	BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9WC;TJ(F);TN(F);TT(F);TZ(F)
BD	BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WFWJ;TK(F);TP(F);TU(F);TV(F)
BG	BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)TY(M)
BH	BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)TZ(M)
BJ	BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)TV(M)
C1	C1;TC
C2	C2;T2

C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
equatable to F3)
CA-CZ = Equatable only to itself. (e.g., CA is
only equatable to CA)

RRB Categories

10 = 10
11 = 11
13 = 13;17
14 = 14;16
15 = 15
43 = 43
45 = 45
46 = 46
80 = 80
83 = 83
84 = 84;86
85 = 85

1 GEO_SSA_STATE_TB — State Table

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01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii

13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada & Islands
57 = Central America and West Indies

1 GEO_SSA_STATE_TB State Table

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58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
66 = Saipan
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa;
otherwise unknown

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

Prior to 5/92

01 = General practice
02 = General surgery
03 = Allergy (revised 10/91 to mean allergy/
immunology)
04 = Otology, laryngology, rhinology
revised 10/91 to mean otolaryngology)
05 = Anesthesiology
06 = Cardiovascular disease (revised 10/91
to mean cardiology)
07 = Dermatology
08 = Family practice
09 = Gynecology--osteopaths only (deleted
10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only)
(revised 10/91 to mean osteopathic
manipulative therapy)
13 = Neurology
14 = Neurological surgery (revised 10/91 to
mean neurosurgery)
15 = Obstetrics--osteopaths only (deleted
10/91; changed to '16')
16 = OB-gynecology

HCFA_PRVDR_SPCLTY_TB

17 = Ophthalmology, otology, laryngology rhinology--osteopaths only (deleted 10/91; changed to '18' if physicians practice is more than 50% ophthalmology or to '04' if physician's practice is more than 50% otolaryngology. If practice is 50/50, choose specialty with greater allowed charges.
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology-osteopaths only (deleted 10/91; changed to '22')
22 = Pathology
23 = Peripheral vascular disease or surgery (deleted 10/91; changed to '76')
24 = Plastic surgery (revised to mean plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only) (deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean diagnostic radiology)
31 = Roentgenology, radiology (osteopaths) (deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted 10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91 to mean chiropractic)
36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean pediatric medicine)
38 = Geriatrics (revised 10/91 to mean geriatric medicine)
39 = Nephrology
40 = Hand surgery

41 = Optometrist - services related to condition of aphakia (revised 10/91 to mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist (revised 10/91 to mean CRNA, anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised 10/91 to mean podiatry)
49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O. certification (certified orthotist - certified by American Board for Certification in Prosthetics and Orthotics.
52 = Medical supply company with C.P. certification (certified prosthetist - certified by American Board for Certification in Prosthetics and Orthotics).
53 = Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
54 = Medical supply company not included in 51, 52, or 53.
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist - orthotist
58 = Individuals not included in 55,56 or 57
59 = Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist--billing independently
63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
64 = Audiologist (billing independently)

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)
67 = Occupational therapist--independent practice
68 = Clinical psychologist
69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
70 = Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)
71 = Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)
72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
76 = Peripheral vascular disease (added 10/91)
77 = Vascular surgery (added 10/91)
78 = Cardiac surgery (added 10/91)
79 = Addiction medicine (added 10/91)
8O = Clinical social worker (1991)
81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)
83 = Hematology/oncology (added 10/91)
84 = Preventive medicine (added 10/91)
85 = Maxillofacial surgery (added 10/91)
86 = Neuropsychiatry (added 10/91)
87 = All other (e.g. drug and department stores) (revised 10/91 to mean all other suppliers)
88 = Unknown (revised 10/91 to mean physician assistant)
90 = Medical oncology (added 10/91)
91 = Surgical oncology (added 10/91)
92 = Radiation oncology (added 10/91)
93 = Emergency medicine (added 10/91)

94 = Interventional radiology (added 10/91)
95 = Independent physiological laboratory
(added 10/91)
96 = Unknown physician specialty
(added 10/91)
99 = Unknown--incl. social worker's
psychiatric services (revised 10/91 to
mean unknown supplier/provider)

Effective 5/92

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology

1	HCFA_PRVDR_SPCLTY_TB	HCFA Provider Specialty Table	
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04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Gynecology (osteopaths only)
(discontinued 5/92 use code 16)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Obstetrics (osteopaths only)
(discontinued 5/92 use code 16)
16 = Obstetrics/gynecology
17 = Ophthalmology, otology, laryngology,
rhinology (osteopaths only)
(discontinued 5/92 use codes 18 or 04
depending on percentage of practice)
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical
pathology (osteopaths only)
(discontinued 5/92 use code 22)
22 = Pathology
23 = Peripheral vascular disease, medical
or surgical (osteopaths only)

(discontinued 5/92 use code 76)
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)
32 = Radiation therapy (osteopaths only) (discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = Crna, anesthesia assistant (eff 1/87)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)

47 = Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for

Certification In Prosthetics And Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company not included in 51, 52, or 53. (Revised 10/93 to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Individuals not included in 55, 56, or 57 (revised 10/93 to mean medical supply company with registered pharmacist)
59 = Ambulance service supplier, e.G., private ambulance companies, funeral homes, etc.
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.G., National Cancer Society, National Heart Associiation, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently practicing)
66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this to mean medical supply company with respiratory therapist
67 = Occupational therapist (independently practicing)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Multispecialty clinic or group practice
71 = Diagnostic X-ray (GPPP) (not to be assigned after 5/92)

1	HCFA_PRVDR_SPCLTY_TB		HCFA Provider Specialty Table

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72 = Diagnostic laboratory (GPPP)
(not to be assigned after 5/92)
73 = Physiotherapy (GPPP) (not to be
assigned after 5/92)
74 = Occupational therapy (GPPP)
(not to be assigned after 5/92)
75 = Other medical care (GPPP) (not to
assigned after 5/92)
76 = Peripheral vascular disease
(eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
(eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
department stores) (note: DMERC used
87 to mean department store from 10/93
through 9/94; recoded eff 10/94 to A7;
NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
(note: DMERC used 87 to mean grocery
store from 10/93 - 9/94; recoded eff
10/94 to A8; NCH cross-walked DMERC
reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Independent physiological
laboratory (eff 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)

A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility
(eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93)
(DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory
therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use:
eff 10/94, but cross-walked from
code 87 eff 10/93)
A8 = Grocery store (for DMERC use:
eff 10/94, but cross-walked from

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

code 88 eff 10/93)

1 HCFA_TYPE_SRVC_TB HCFA Type of Service Table

1 = Medical care
2 = Surgery
3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services
0 = Whole blood only eff 01/96,
whole blood or packed red cells before 01/96
A = Used durable medical equipment (DME)
B = High risk screening mammography
(obsolete 1/1/98)
C = Low risk screening mammography
(obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies
(eff 04/95)
F = Ambulatory surgical center (facility
usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)

I = Purchase of DME (installment basis)
(discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95)
(renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics,
orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies
(eff 04/95)
T = Psychological therapy (term. 12/31/97)
outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96),
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery
(obsoleted 1/97)
Z = Third opinion on elective surgery
(obsoleted 1/97)

1 LINE_ADDTNL_CLM_DCMTN_IND_TB — Line Additional Claim Documentation Indicator Table

0 = No additional documentation
1 = Additional documentation submitted for
non-DME EMC claim
2 = CMN/prescription/other documentation submitted
which justifies medical necessity
3 = Prior authorization obtained and approved
4 = Prior authorization requested but not approved
5 = CMN/prescription/other documentation submitted
but did not justify medical necessity
6 = CMN/prescription/other documentation submitted
and approved after prior authorization rejected
7 = Recertification CMN/prescription/other
documentation

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

Prior To 1/92

1 = Office
2 = Home
3 = Inpatient hospital
4 = SNF
5 = Outpatient hospital
6 = Independent lab
7 = Other
8 = Independent kidney disease treatment center
9 = Ambulatory
A = Ambulance service
H = Hospice
M = Mental health, rural mental health
N = Nursing home
R = Rural codes

Effective 1/92

11 = Office
12 = Home
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF) (eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally retarded

55 = Residential substance abuse treatment facility
56 = Psychiatric residential treatment center
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation facility
62 = Comprehensive outpatient rehabilitation facility
65 = End stage renal disease treatment facility
71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

99 = Other unlisted facility

1 LINE_PMT_IND_TB — Line Payment Indicator Table

1 = Actual charge
2 = Customary charge
3 = Prevailing charge (adjusted, unadjusted gap fill, etc)
4 = Other (ASC fees, radiology and outpatient limits, and non-payment because of denial.
5 = Lab fee schedule
6 = Physician fee schedule - full fee schedule amount
7 = Physician fee schedule - transition
8 = Clinical psychologist fee schedule
9 = DME and prosthetics/orthotics fee schedules (eff. 4/97)

1 LINE_PRCSG_IND_TB — Line Processing Indicator Table

A = Allowed
B = Benefits exhausted
C = Noncovered care
D = Denied (existed prior to 1991; from BMAD)

I = Invalid data
L = CLIA (eff 9/92)
M = Multiple submittal--duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided (contractor #88888) -
    voluntary agreement (eff. 1/98)
R = Reprocessed--adjustments based on
    subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided - IEQ contractor
    (eff. 7/76)
U = MSP cost avoided - HMO rate cell
    adjustment (eff. 7/96)
V = MSP cost avoided - litigation
    settlement (eff. 7/96)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
    match project
Z = Bundled test, no payment
    (eff. 1/1/98)

1 LINE_PRVDR_PRTCPTG_IND_TB — Line Provider Participating Indicator Table

1 = Participating
2 = All or some covered and allowed
    expenses applied to deductible Participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some
    covered and allowed expenses applied
    to deductible Non-participating.
6 = Assignment not accepted and all covered
    and allowed expenses applied to deductible
    non-participating.
7 = Participating provider not accepting
    assignment.

1 NCH_CLM_TYPE_TB — NCH Claim Type Table

10 = HHA claim

20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
41 = Outpatient 'Full-Encounter' claim
     (available in NMUD)
42 = Outpatient 'Abbreviated-Encounter' claim
     (available in NMUD)
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Inpatient 'Abbreviated-Encounter claim
     (available in NMUD)
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
73 = Physician 'Full-Encounter' claim
     (available in NMUD)
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

NCH_EDIT_TB — NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > $100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A1X1 = (C) PERCENT ALLOWED INDICATOR
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA

D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER

1 NCH_EDIT_TB NCH EDIT TABLE
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0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636

0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME HCPCS
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL

2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

1 NCH_EDIT_TB NCH EDIT TABLE
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2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091

33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID

4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL

46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK

51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0

5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
524Z = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0

527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR

1 NCH_EDIT_TB — NCH EDIT TABLE

5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5378 = (C) SERVICE DATE < AGE 50
5399 = (U) HOSPICE PERIOD NUM MATCH
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE

59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID

6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG

6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.

1 NCH_EDIT_TB — NCH EDIT TABLE

69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO

6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78X1 = (C) THRU DATE INVALID
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING

8031 = (U) HH PT A REMAINING > 0

1 NCH_EDIT_TB — NCH EDIT TABLE

8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE

93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID

94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE,INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0

98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

1 NCH_NEAR_LINE_RIC_TB — NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)
W = Part B institutional claim record (outpatient (OP), HHA)
U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)
M = Part B DMEPOS claim record (processed

by DME Regional Carrier) (effective 10/93)

1 NCH_PATCH_TB — NCH Patch Table

01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.

02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.

03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' ocnversion, patch applied to Nearline claims where garbage or nonnumeric values.

04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.

05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.

06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) --

applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is calculated to determine the correct value; if greater than 64, 1st position MSC ='1'; if less than 65, 1st position MSC = '2'.

07 = Missing CWF bene mediare status code derived (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing, except claims with unknown DOB and/ or Claim From Date='0' (left blank). Bene age is calculated to determine missing value; if greater than 64, MSC='10'; if less than 65, MSC = '20'.

08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/ SNF (the problem was only found with OP/HHA/ Hospice claims). The problem was corrected 6/25/99.

11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch

was done for records with NCH Daily Process
Date 1/4/99 - 5/14/99.
12 = Missing claim-level HHA Total Visit Count --
service years 1998, 1999 & 2000 patch applied
during Version 'I' conversion of both the
Nearline and SAFs. Problem occurs in those
claims recovered during the missing claims
effort.
13 = Inconsistent Claim MCO Paid Switch made consistent
with criteria used to identify an inpatient
encounter claim -- if MCO paid switch equal to blank
or '0' and ALL conditions are met to indicate an
inpatient encounter claim (bene enrolled in a risk
MCO during the service period), change the switch to
a '1'. The patch was applied during the Version 'I'
conversion, for claims back to 7/1/97 service thru date.

1	NCH_STATE_SGMT_TB		NCH State Segment Table
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01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi

26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennesee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada
57 = Central America & West Indies

1	NCH_STATE_SGMT_TB		NCH State Segment Table
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58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = US Possessions
97 = Saipan - MP
98 = Guam
99 = American Samoa